of teaching and learning with each patient seen that is important. In a sense that is true for common illness but not when one wishes to learn about the less common disorders. The larger, especially public, institutions have the advantage, evidence for this being beyond the scope of this communication.

How then can a public teaching hospital cope with this increasing financial strain and yet preserve its graduate education programs? One possible solution might be that as private teaching hospitals reduce their care to the poor and uninsured patients, they must also reduce or eliminate their graduate teaching programs. Some of the funds saved could be redistributed to public teaching hospitals for their graduate education activities which might include sending their trainees to private institutions for portions of their training. This is already being done effectively by many academic health centers and medical schools. Additional financing for graduate medical education could be provided by any or all of the following: (1) The private sector and all health insurance programs should be asked to participate in this function, not just federal, state and local governmental agencies. (2) Although politically unpopular, all alcohol, tobacco and ethical drug products should be taxed, with the proceeds earmarked for health care, a portion of which could be used to support graduate medical education. (3) The academic health centers should seek private funding through grants and endowments to support graduate medical education to the same extent that research support is now funded.

As in all other fields of medical care, graduate medical education is not only being subjected to programmatic stresses but is also being threatened by economic hardship. Characteristically, the academically affiliated public hospitals are experiencing the greatest negative impact. Measures must be taken by all those concerned in order to preserve the high quality of training programs from which this country has benefited for many years.

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Medicare-Funded Cardiac Transplants

TO THE EDITOR: The article by Renlund and associates in the May issue[1] details the successful experience of a cardiac transplant center that would not qualify for funding under Medicare's proposed guidelines.

We are specifically concerned that the designation of *only* a few centers will have an adverse effect on other successful programs. If third-party payers adopt these recommendations and only reimburse at those federally designated centers, 76 of the 86 centers that presently perform cardiac transplantation would not be able to continue to do so. Further, with the low minimal survival rates that have been recommended, and the three-year length of time for a program to prove itself successful, we feel the Department of Health and Human Services is inappropriately emphasizing the quantity of transplants performed versus the quality or survival rates of different programs.

As one of the four most active cardiac centers in California, our program has performed 18 transplants over a 19-month period with a 100% survival rate to date. We have worked diligently at establishing a multidisciplinary and successful cardiac transplant program that is committed to serving the people of San Diego County. In addition, a coordinated research effort at our institution to define noninvasive immunologic and hemodynamic correlates of transplant rejection has already yielded published results. We feel that our success in cardiac transplantation has important positive input both on health care delivery in our region and on transplantation in general.

We hope that Medicare closely evaluates their proposed guidelines before making them final, thus avoiding a negative impact on many programs. Highly successful transplant programs should continue to be supported.

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Heart Disease and Mortality

TO THE EDITOR: Regarding the recurrent discussion concerning dietary cholesterol in atherosclerosis, the most recent iceberg tipped on pages 621-622 in your May 1987 issue of the journal.[1,2] Both Dr Wolfstein and Dr Desmond are correct. Dr Desmond thinks she answers Dr Wolfstein's caveat by quoting the consensus conference in December 1984, and she quotes them accurately—that is, that they talked about "heart attacks." These data are now rather firm, especially with reference to the most recent study presented in the *American Journal of Cardiology* a year ago.[3]

Dr Desmond, however, incorrectly extrapolated the statement on heart attacks to mortality in her article in the January 1987 issue.[4] This is where Dr Wolfstein is right. Coronary artery disease mortality has not as yet been documented to be reduced by cholesterol lowering.

Pearce and Dayton many years ago in the Veteran's Administration Hospital study at Los Angeles showed that the death rate stayed about the same over a five-year study.[5]

Once again, arteriosclerosis is "the blindman and the elephant."[6]

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